Patient Information

2170 Ironwood Center Drive
Coeur d' Alene, Idaho 83814
Phone: 208.667.1988 Fax: 208.765.5654

8238 N. Governmeny Way
Hayden, ID 83835
Phone: 208-762-2100 Fax: 208-762-2101

East 12615 Mission, Ste. 109
Spokane Valley, W A 99216
Phone: 509-891-2623 Fax: 509-891-2624

Basic Information

Name: _____ Age: _____ Birthdate: _____

Guardian (if patient is a minor): _____ Relationship: _____

Address: _____ Social Sec#: _____

City: _____ State: _____ Zip _____ Email: _____

Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Sex: M ( ) F ( ) Marital Status: S ( ) M ( ) D ( ) W ( ) Employer: _____

Family Physician: _____ Phone: ( ) _____

Referring Physician (if different from family physician): _____ Phone: ( ) _____

Injury/Illness occurred from? Work( ) Auto Accident( ) Other( )Have you had Surgery? Y( ) N( ) Date: _____

Have you received any Physical, Occupational, Speech or Massage Therapy in the current insurance year? (Y) (N)

How did you hear about our office? ( ) Social Media ( ) Website ( ) Referral ( ) Family/Friend ( ) Other

Emergency Contact & Responsible Party *(Person to receive Billing Statement)*

In case of emergency call: _____ Phone: ( ) _____ Relationship: _____

Responsible party name: _____ Social Sec#: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Phone: _____

Primary Insurance _____ Subscriber's Name: _____ Sub's SS#: _____

Sub's Birthdate: _____ Sub's ID#: _____ Group#: _____

Employer: _____ Sub's Relationship to Patient: _____

Secondary Insurance _____ Subscriber's Name: _____ Sub's SS#: _____

Sub's Birthdate: _____ Sub's ID#: _____ Group#: _____

Employer: _____ Sub's Relationship to Patient: _____

Medical History

Please check if you have had any of the following: ( )High Blood Pressure, ( )Diabetes, ( )Cancer, ( )Heart Disease, ( )Allergies, ( )Metal implant, ( )Pacemaker, ( )STD, ( )Hernia, ( )Nervous Disorders, ( )HIV, ( )Pregnancy, ( )Kidney problems, ( )Headaches, ( )Heart Attack, ( )Seizures, ( )Hep. A/B/C, ( )MRSA

Current Medications: _____

Recent Surgeries: _____

Allergies: _____

Insurance Authorization and Assignment

I hereby consent to and authorize the administration of all medical treatment. I also authorize Lake City Physical Therapy, PA to furnish information to and receive information from the referring physicians concerning my condition and treatments rendered. I request that payment of authorized Insurance benefits be made on my behalf to Lake City Physical Therapy, PA for services furnished to me by this physical therapy office. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____ Date: _____

Medicare Authorization Agreement: I request that payment of authorized Medicare benefits be made on my behalf to Lake City Physical Therapy, PA for any services furnished to me by this physical therapy office.

Patient Signature: _____ Date: _____